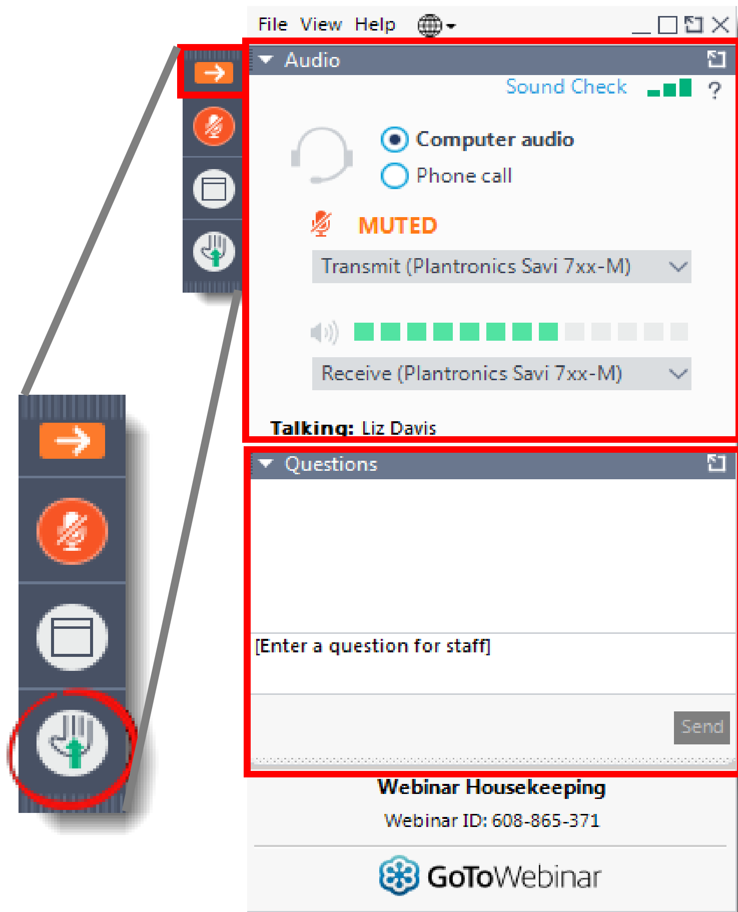
SIM PCMH Initiative Office Hours

COMMUNITY LINKAGES AND SOCIAL DETERMINANTS OF HEALTH

OCTOBER 22, 2019

Housekeeping:
Webinar Toolbar Features



Your Participation

Open and close your control panel

Join audio:

- Choose **Mic & Speakers** to use VoIP
- Choose **Telephone** and dial using the information provided

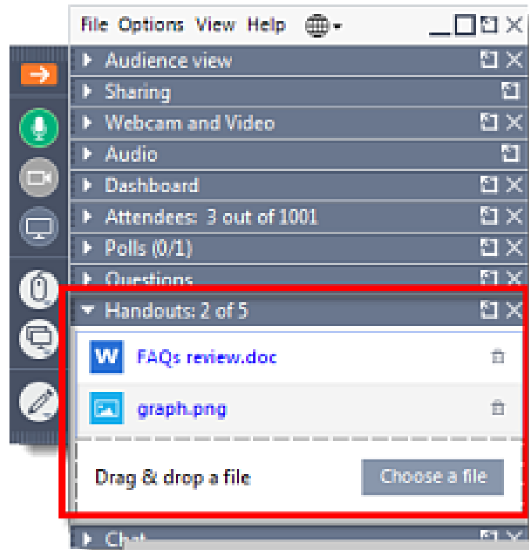
Submit questions and comments via the Questions panel

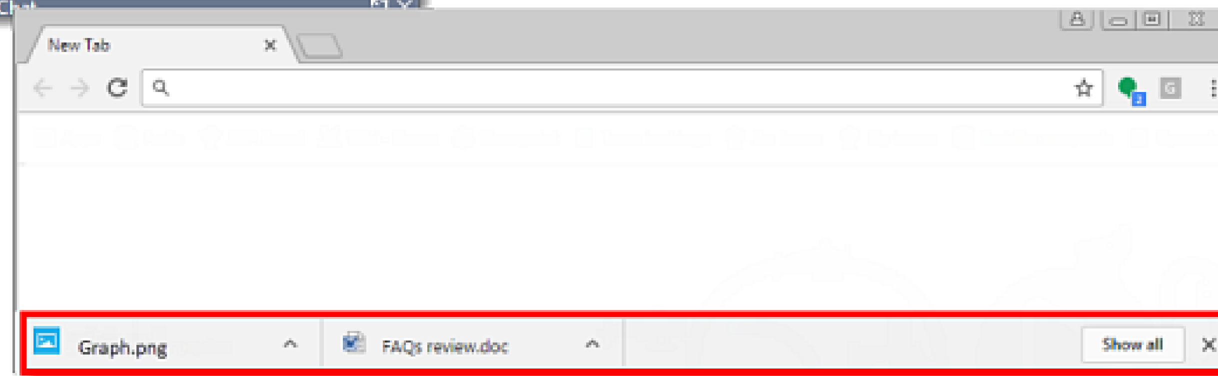
Note: If time allows, we will unmute participants to ask questions verbally.

- Please raise your hand to be unmuted for verbal questions.

NOTE:
In the event that there is not time to answer questions live, all questions submitted via the Question Function of the GoToWebinar toolbar will be recorded, an FAQ generated and posted to our webpage

Housekeeping:
Webinar Resources/Handouts





Handouts

- Webinar slides & other resources are uploaded to the "Handouts" section of your GoToWebinar Toolbar.
- Note: You may need to check the download bar of your browser to view the resources.

IHA: Impacting Community Health by Addressing Social Needs

DAYANI WAAS, SENIOR PROJECT MANAGER

IHA

IHA
Multi-specialty Group, Southeastern MI

Established in 1994, one of the largest MI multi-specialty groups

A wholly-owned subsidiary of Saint Joseph Mercy Health System and a member of Trinity Health

Delivering > one million patient visits/yr in 74 practice locations across SE MI

As of 12/31/2018, 274,948 active Primary Care patients, 10.3% (28,229) Medicaid as the primary insurance for FM, IM, and Peds

Employs more than 2,400 staff; >700 providers (physicians, nurse practitioners, physician assistants, midwives)

Offers extended office hours, urgent care services, online patient diagnosis, treatment and appointment access tools

NextGen is the EMR system utilized; moving to EPIC Jan 2020

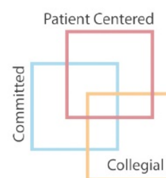
Screening for Social Determinants of Health

Requirement of the State Innovation Model

Screening as a community partnership with Michigan Medicine and HVPA

Goals of Screening:

- Identify the needs of our patients
- Connect those patients with resources to address those needs
- Decrease unnecessary healthcare utilization
- Improve the health of the population by better understanding and addressing community-wide screening data



SDoH Screening Categories

Initial Screening Domains
Food insecurity
Housing instability
Utility needs
Ability to pay for medical expenses
Childcare
Elderly care
Transportation to Doctor's office
Literacy
Social Isolation

*Screening question adjustment made

- Worked with community resource agencies to select screening questions and assess capacity
- Engaged with 2-1-1 of Southeast Michigan to train IHA staff on resource database

SIM
MDHHS State Innovation Model

Standard Work for SDoH Screens

- Developed standard work instructions over a 4-month pilot with 5 practices
- Step-wise launch to 38 primary care practices in December '18
- Screen at Health Maintenance, New OB, Diabetic, Transitions of Care Visits
- Paper screening form → MA documents in EMR SDoH Template
- Provider discusses screening results; Referral staff provides resources to patient over phone or in-person

SIM MDHHS State Innovation Model

Clinical-Community Linkages

Division identifies staff members. OB: Nurses, FM/IM: Call Center, Pediatrics: Care Managers

Empathy, SDoH template, Workflow training provided through in-person/Healthstream

Linkage is documented in EMR Referral template

01/12/2018 09:44 AM : "*iIntake"
01/12/2018 09:44 AM : "IOrder Management"

All Orders | Diagnostics | Lab Orders | Office Services | Procedures | Referrals | Other Orders | Immunizations | Standing Orders

Action:
1st call
2nd call
3rd call
Order submitted
Referring office to follow up - duplicate order
Referring Office to follow up - more information required
Referring Office to follow up - Outreach complete
Referring Office to follow up - patient declined
Sent back to specialist

Select status of r...:
cancelled
completed
obtained
ordered
result received
scheduled

SDOH Ordered comment:
Patient contacted resource and no response
Patient contacted resource and need met
Patient contacted resource and need not met. Additional resource provided
Patient contacted resource and need not met. Declined further assistance.
Patient did not contact resource and need not met. Additional resource provided
Patient did not contact resource and need not met. Declined further assistance
Patient did not contact resource and need met
Due date updated per chart note
Due date updated, original blank
Patient declines
Patient expired
Patient portal reminder
Recall complete
Reminder at OV
Reminder Letter

Date	Time	User	Order	Action	Comments
01/12/2018	9:47 AM	Joselyn Foster RMA	Referral: Literacy	order submitted	

Documentation in EMR

1st Attempt

- 1st call
- Contact made. Status: Complete. Action: 1st Call. Comment: PIC-LIST
- No Contact made. Status: Ordered. Action: 1st Call

2nd Attempt

- 2nd call
- Contact made. Status: Complete. Action: 2nd Call. Comment: PIC-LIST
- No Contact made. Status: Ordered. Action: 2nd Call

3rd Attempt

- Letter. No Contact made. Status: Ordered. Action: 3rd Call. Comment: Recall Complete

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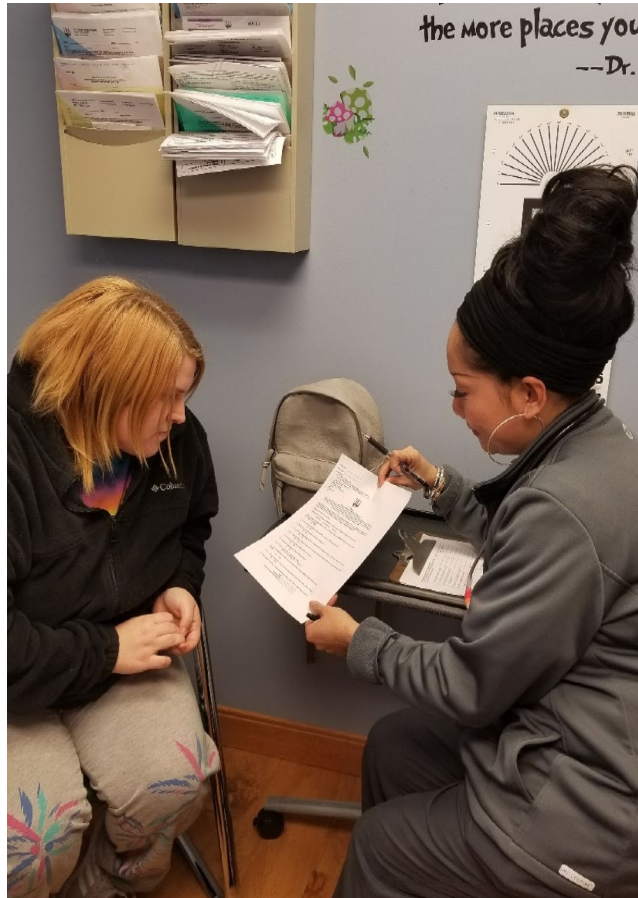
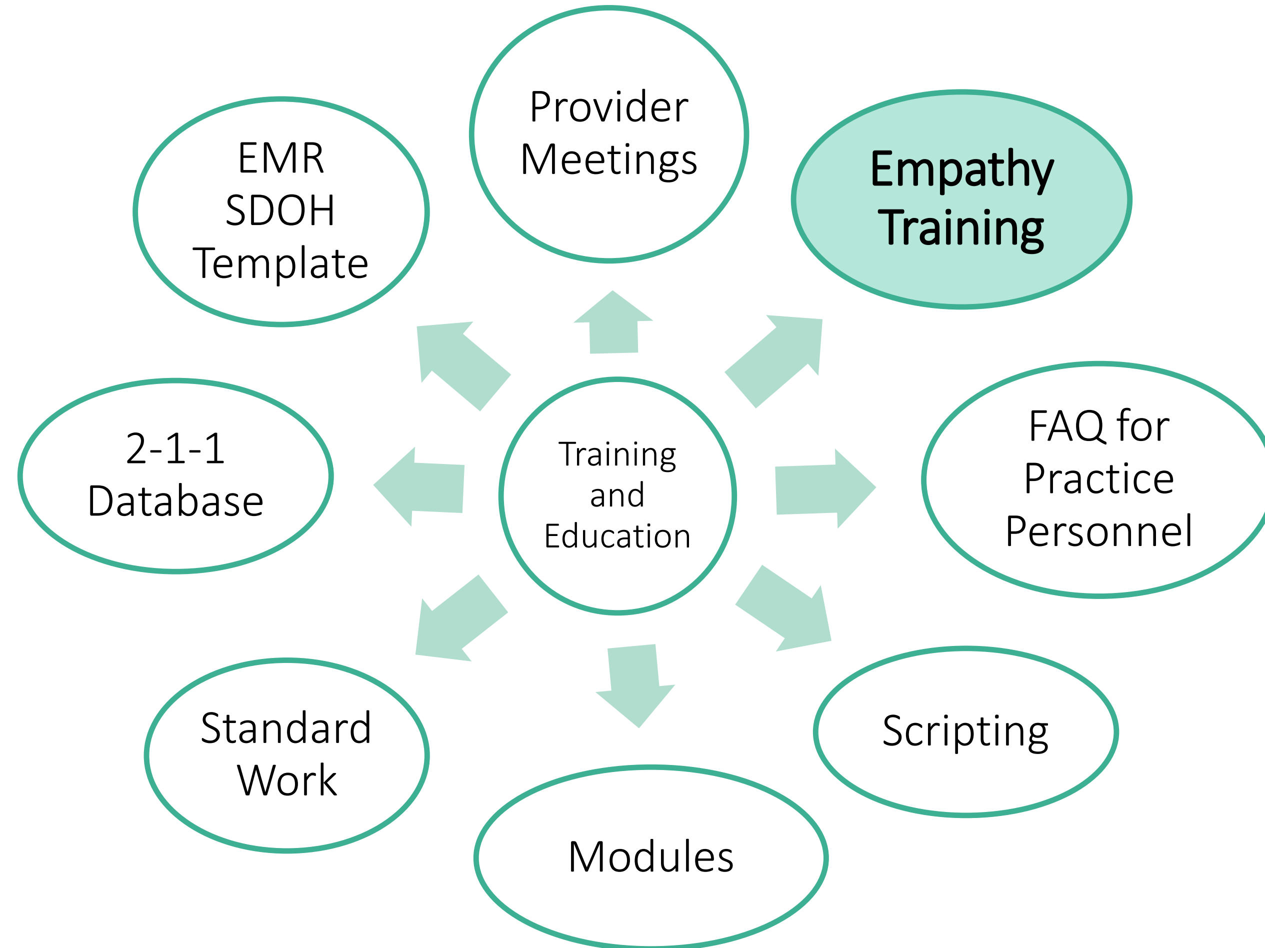
Training and Education





SDoH Program Evaluation Metrics

Total SDoH Screens and Count of Patient Declined
Total SDoH Applicable Visit
Screen Rate
% Positive Screens
% One Positive Needs
% Multiple Positive Needs
% Screens with Referral Requested
% of Referral Cases Closed
% of Positive SDoH Domain
% SDoH Domain Referral Requested

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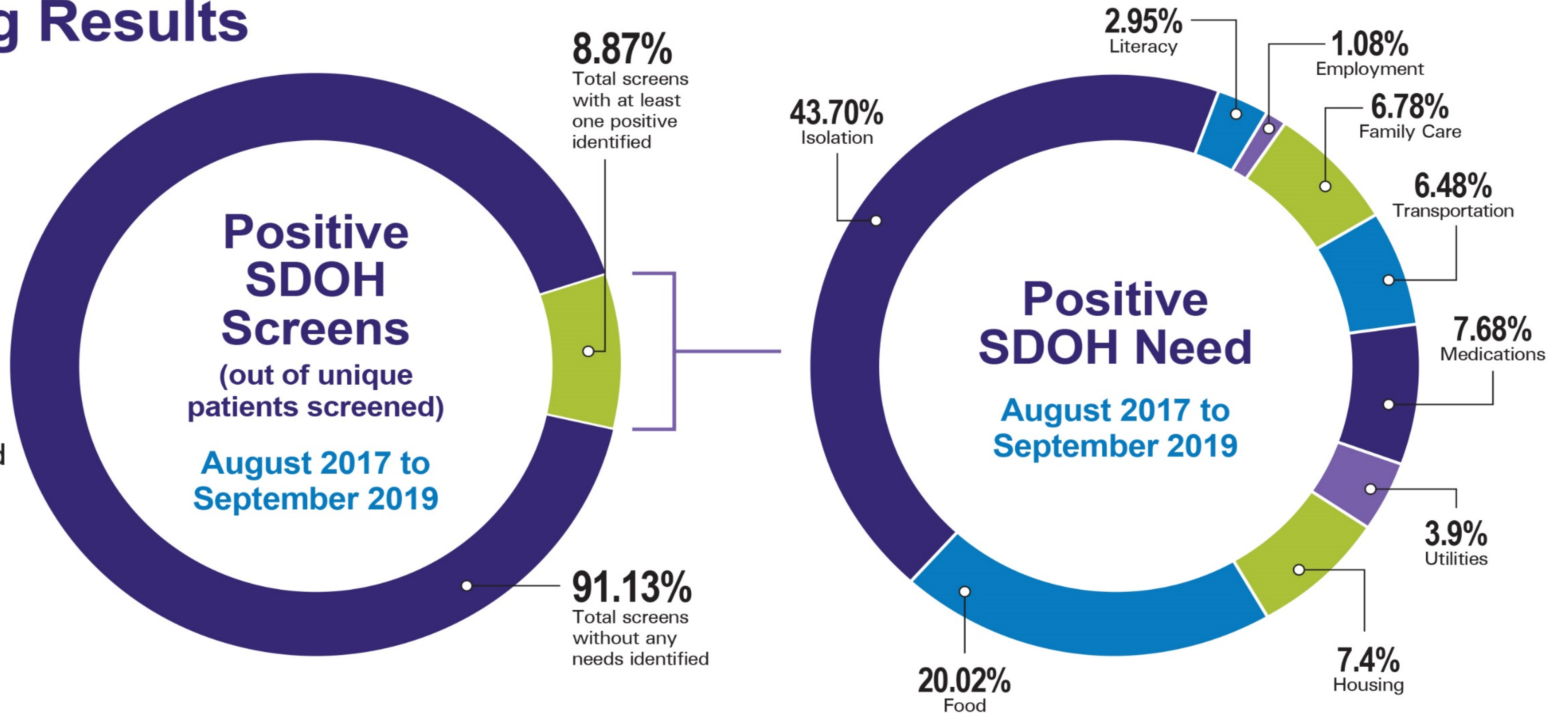
Screening Results

Referral Cases Closed 08/01/2017 - 01/01/2019*: 54.53%



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MDHHS State Innovation Model

SDoH at HFPC

TRACY MATTHEWS, LMSW-CCM & ERIN ARMSTRONG , RN-CCM
HURON FAMILY PRACTICE CENTER

Huron Family Practice Center
At a Glance

Rural community

2500 pts: ~45% Medicaid ~45% Medicare ~10% Private Insurance

2 Hospitals

1 full time MD and 1 part time NP (CM trained)

1 full time RN-CM

1 part time SW-CM

1 part time Pharm-CM

Huron Family Practice Center
At a Glance

Community Demographics

Making Clinical Community Linkages
- All Staff =clinical and clerical

Training our Staff Members in Creating/Sustaining Community Linkages:
- Staff Meetings
- CM training for staff throughout office
- Huddles

Key points:
- Use of the same scheduling calendar to coordinate/encourage interdisciplinary communication
- SW patient follow-up - clinical judgment
- BSW student

Linkage Monitoring and Follow Up Data Collected

How we conduct linkages monitoring and follow up

- Linkage Monitoring Process
  - SDoH Tool
  - Office team members , SW-CCM reviews, linkages made
- Common Referrals
  - Counseling agencies, 211, Help Card, Food Bank, Utilities, DHS, Housing Commission

-Monitoring: Contact patients 10-14 days

-Follow Up Processes: PC/ Face to Face

Recent Data

- We're a small practice ☺
  - Data used from this program
  - High comorbidity and Mental Health correlation
  - Decreased ER use
  - Outcomes-show me the numbers
  - Top need areas reported
  - Top need areas pts request support on

Questions?